MINUTES
MEETING OF
INDIGENT & CHARITY CARE AD HOC COMMITTEE
Southside Medical Center
1046 Ridge Avenue, SW,
Atlanta, GA 30315

Friday, December 10, 2004
11:00 am - 3:00 pm

David M. Williams, MD., Chair, Presiding

MEMBERS PRESENT

Cal Calhoun
Jeffrey Crudele
Daniel DeLoach, MD (via conference call)
Kurt Stuenkel, FACHE

MEMBERS ABSENT

Charlotte McMullan
Eric Randolph, MD
Jim Connolly
W. Douglas Skelton, MD
Tony Strange

GUESTS PRESENT

Jeffery Baxter, Nelson Mullins
Brian Crevasse, Parker, Hudson, Rainer & Dobbs
Darcy Davis, Phoebe Putney
Cam Grayson, Medical Association of Georgia
Joanne Johansen, Savannah Plastic Surgery Assoc.
Bill Lewis, Phoebe Putney
Erin Moriarty, Atlanta Business Chronicle
Stacey Pineo, Phears & Moldovan
Leah Watkins, Powell Goldstein

STAFF PRESENT

Kimberly Anderson
Charmone Grant JD
Richard Greene, JD
Matt Jarrard
Isiah Lineberry
Brigitte Maddox
Robert Rozier, JD
Geeta Singh
Stephanie Taylor
Carlos Williams

WELCOME

The Indigent & Charity Care Ad Hoc Committee meeting officially commenced at 11:25 am. David Williams, MD, Chair, welcomed members and guests and provided a brief description of Southside Medical Center (SMC) noting that SMC, a safety net provider, is a 38-year old community health center and is the oldest community health center in Georgia. The center sees approximately 130,000 patients per year and has seven satellite locations. It provides a range of services including primary care services pediatric, adult medicine, OB/GYN, optometry, podiatry, cardiology, urology, radiology, substance abuse programs, and other services.

REVIEW AND APPROVAL OF MINUTES OF NOVEMBER 19, 2004 MEETING

Dr. Williams asked for a motion to approve the minutes of the November 19th meeting. Jeff Crudele requested some additional time to review the minutes, noting that he had been traveling and did not have the opportunity to review the draft meeting minutes. Committee members agreed to postpone acceptance of the minutes until the end of the meeting to allow Mr. Crudele additional time to review them.

PUBLIC COMMENTS

Dr. Williams called on guests to provide public comments. A copy of comments made by Joanne Johansen, Practice Manager of Savannah Plastic Surgery Associates, is provided as Appendix A.

DELINEATION OF ISSUES IDENTIFIED BY THE DEPARTMENT

Dr. Williams called on Robert Rozier to discuss the Department's proposed draft Definitions of Indigent & Charity Care. Mr. Rozier distributed a draft document entitled "Indigent & Charity Care Definitions - Working Paper" to the committee. He noted that this proposed document incorporates definitions from other states, as well as information gleaned from previous committee discussions. Mr. Rozier outlined the definitions as follows:

1. ADVERSE COLLECTION PRACTICES

Department's Proposed language:

Patient charges shall not be considered indigent or charity care if the health care facility has pursued adverse collection practices against the patient or responsible party for payment of the services to be so designated.
Adverse collection practices are those practices employed to collect payment for services rendered the outcome of which may cause an adverse affect to the patient's or responsible party's financial status.
Adverse collection practices include:

1. *Placing a lien against the personal or real property of the patient or responsible party;*
2. *Reporting failure to pay for the services to credit reporting agencies;*
3. *Garnishing the wages of the patient or responsible party;*
4. *Seeking any judgment or recovery from a Court of Law or Equity;*
5. *Pursuing any collection action or policy which does not comply with the Fair Debt Collection Practices Act; and*
6. *Selling the patient's account for such services to a third party collection or recovery agency which retains a percentage of any such collection or recovery.*

Adverse collection practices do not include:

1. *Referring the patient's account for such services to a third party collection or billing agency which is paid a set fee by the health care facility for rendering such billing or collection services, provided that the health care facility has notified the collection or billing agency of its indigent and charity care policies and has contracted with such agency to follow and apply such policies.*

The health care facility shall have written policies about when and under whose authority any debt for services rendered is advanced for collection.

Cal Calhoun asked Mr. Rozier to define "set fee" as is referenced in adverse collection practice.

Mr. Rozier stated that Rhathelia Stroud, who could not be present at today's meeting, had made a point at the previous committee meeting that recovery agents who made a profit from actually taking percentages of revenue recovery should be distinguished from collection agents who are paid a specified amount for collecting or billing patients.

Mr. Crudele said that he does not believe that providers would have any general issues with the six items listed under the "adverse collection practices" section, however the preamble to that section is very broad, specifically where it states: *Adverse collection practices are those practices employed to collect payment for services rendered the outcome of which may cause an adverse affect to the patient's or responsible party's financial status.* He said that collection activities that are used by the provider community are quite varied. He noted that use of the word "may", presents an unclear picture of the requirements to the provider community.

Richard Greene said that it would be inappropriate to attempt to create an exhaustive list of processes that would be considered "adverse collection practices". He asserted that the committee, for this reason, needs to make recommendations that provide guidance to the Department rather than create an exhaustive list of adverse collection practices. He suggested that the sentence: "Adverse collection practices include…." be changed to "Adverse collection practices include, but are not limited to". Committee members agreed to this recommended change.

Mr. Rozier asked Mr. Crudele if he would be more agreeable to the definition if the wording in the second paragraph of the "Adverse Collection Practices" section was changed from "may cause" to "which cause". Mr. Crudele agreed with Mr. Rozier's recommendation.

Cal Calhoun made the suggestion that the second paragraph of this definition be eliminated in its entirety.

Dr. DeLoach pointed out that it makes it very difficult for providers to know when something "may cause an adverse affect".

Mr. Greene said that all of the issues in the document are so intertwined that it is very difficult to examine one section of the Working Paper in isolation of other sections. He recommended that the committee review the first few pages and then return to the specific definition and calculation sections. The committee agreed to this approach.

Mr. Rozier explained that once the committee decides what should be covered under the topics of adverse collection practices, early designation process, distinguishing bad debt from charity care, and

miscellaneous provisions, then the definitions of Indigent and Charity care should become much clearer, as these topics will be included in those definitions.

2. COMPONENTS TO ENCOURAGE EARLY DESIGNATION

Department's Proposed Language:

Patient charges shall not be considered indigent or charity care if the health care facility:

1. *Does not have written indigent and charity care policies which define and delineate income-testing standards for designating services rendered as such;*
2. *Does not have written indigent and charity care policies which establish and provide for financial counseling to uninsured and underinsured patients and responsible parties;*
3. *Does not conspicuously display notices concerning the indigent and charity care policies of the health care facility in appropriate locations, such as inpatient and outpatient admissions areas, throughout its facility;*
4. *Does not provide copies of its written indigent and charity care policies to patients and responsible parties on request;*

Mr. Rozier noted that this is also a mechanism, from an accounting standpoint, to distinguish between bad debt and charity care. He noted that most of these provisions were taken from Medicare requirements or from the Department's Indigent Care Trust Fund requirements.

3. DISTINGUISHING BAD DEBT FROM CHARITY CARE

Department's Proposed Language:

Patient charges shall not be considered indigent or charity care if the health care facility:

1. *Does not have established and separate accounts for indigent care, charity care, and bad debt. Such accounts shall include a detailed listing of the patient accounts that have been designated as such.*
2. *The health care facility shall maintain documentation of a patient's or responsible party's application for financial assistance through the health care facility's indigent or charity care program and policies including, but not limited to:*
    a. *Individual Financial Documents such as tax forms, pay stubs, documentation of income, etc.;*
    b. *the facility's or provider's documentation of financial questionnaires or interviews, if any;*
    c. *Documentation of additional or other medical bills for which the patient or responsible party is responsible;*
    d. *Documentation of the methods used to determine that the patient or responsible party may be classified as indigent or charity care; and*
    e. *Documentation of any and all collection efforts made.*

Dr. DeLoach mentioned that the requirements under this section seem to place a large administrative burden on small private practices. He asserted that on the front end of a surgical procedure or medical encounter, there might be no indication or suspicion that a patient is a candidate for either charity or indigent care. It is only after the service is provided that it may become an issue. He stated that many times when patients are faced with large bills, they might realize that their insurance is either not in affect,

not valid, or may not cover the entire bill. In such a case, patients may qualify for "indigent" status, but many times they may not return to the doctor's office. He asserted that in these instances, it is impossible to collect information because the patient will not return for a follow-up, and many times, based on the limited information, (provided by family members, for example), the provider may write the case off as charity care because all of the sources that are available point in that direction. He explained that for this reason the documentation, which the proposed definitions are requiring, would be impossible for providers to produce. He further argued that the proposed requirements do not conclusively define all scenarios of "charity care" that could be provided by physicians in private practice.

In response to Dr. DeLoach's comments, Mr. Greene pointed out that the draft rules were written with hospitals in mind. He said that the Department recognizes that there are ambulatory surgery centers, home health agencies, and other facilities that have an indigent care commitment. He said that it is within the purview of this committee to make recommendations to consider more facility-specific definitions. He suggested that once the committee can agree on some general definitions, then the group could determine whether they would apply to all facilities types.

4. MISCELLANEOUS STANDARDS

Department's Proposed Language:

1. *Patient Charges designated as indigent or charity care shall not include professional fees unless such fees are for services rendered by professionals directly employed by the health care facility.*
2. *A patient or responsible party shall only be classified for indigent care if the individual or family income of such person is less than or equal to 125% of FPG.*
3. *A patient or responsible party shall only be classified for charity care if:*
    a. *the individual or family income of such person is more than 125% of FPG;*
    b. *documentation of the individual or family income has been obtained by the facility or provider;*
    c. *the documentation provided meets the income-testing standards of the facility's or provider's charity care policy; and*
    d. *only the amount of forgone revenue for services rendered that meet the income standards of the facility or provider are counted as charity care.*
4. Charity Care shall not include bad debt.

COMMITTEE DISCUSSION

Mr. Rozier invited committee members to provide comments and concerns regarding the definitions discussed thus far including: adverse collection practices, early designation process, distinguishing bad debt from charity care, and miscellaneous standards.

Mr. Crudele thanked the Department for its work to date. With regards to the section of the Working Paper that discusses "early designation", he suggested that a summation of providers' policies would be more appropriate as opposed to requiring providers' entire policies. He also suggested not using the term "income standards", under miscellaneous standards. Additionally, he said that several states specifically provide for the use of attestations and that HCA allows facilities to honor attestations. He suggested that allowing attestation would reduce the administrative burden on providers.

In response to Mr. Crudele's statements, Dr. Williams commented that policies that allow for attestations without any requirement of follow-up documentation leave the system open to abuse. He noted that attestations are routinely accepted at Southside Medical Center, with the understanding that the patient has to bring back the appropriate documentation within a specified period of time; otherwise the full charge would be applied to the patient's account. He said that this process reduces the administrative burden on the center, because the responsibility to provide the documentation is placed on the patient.

5. DEFINITION OF BAD DEBT

Department's Proposed Language:

(9) "Bad debt" means all patient charges for inpatient or outpatient medical services, due from patients or other responsible parties, that have not been or are not expected to be collected for patients identified as having income levels greater than 125% of Federal Poverty Guidelines (FPG) and which are not otherwise categorized as charity care (as defined at 111-2-2-.01(14)), contractual adjustments, Hill-Burton (if applicable), or other free care. Bad debt results from the unwillingness of a patient to pay the charges for which the patient is responsible. To determine whether an amount should be classified as bad debt, the Department shall follow the following standards:

(a) An amount shall not be treated as bad debt for patients whose income is less than or equal to 125% of the federal poverty guidelines; and

(b) Bad debts must be differentiated from charity care as defined at 111-2-2-.01(14). Patient charges otherwise eligible for classification as charity care should be included in the bad debt category if all conditions of the charity care definition are not met; and

(c) Patient charges shall only be considered bad debt if such forgone revenue is recorded to a bad debt account and a detailed list of such account is maintained.

Mr. Crudele questioned the inclusion of (a) in this definition. He said that rather than specifically stating this language, it should be linked to the definition. Mr. Rozier agreed with Mr. Crudele's suggestion.

6. DEFINITION OF CHARITY CARE

Department's Proposed Language

(14) "Charity care" means patient charges, or a portion of patient charges, for inpatient or outpatient medical services rendered to uninsured or underinsured, income-tested patients whose individual or family income is greater than 125% of the Federal Poverty Guidelines (FPG) when such charges are written off to a valid charity account in accounting records pursuant to a formal and official written charity policy. A detailed listing of patient accounts of portions of patient accounts contained in the charity account shall be maintained.

(a) The formal and official written charity policy shall be institution specific and outline the financial and other qualifications of patients for waiver of some or all of the allowable financial obligations for services provided.

1. *The formal and official written charity policy shall establish and provide for financial counseling to uninsured and underinsured patients and responsible parties. No amount of patient charges shall be reported or classified as charity care unless the health care facility's written policy establishes standards for the provision of financial counseling to such persons;*
2. *Notices concerning the formal and official written charity policy shall be conspicuously displayed within the health care facility in appropriate locations, such as inpatient and outpatient admissions areas, throughout the facility. No amount of patient charges*

shall be reported or classified as charity care unless the health care facility has posted such notices;

3. *The health care facility shall provide copies of its written charity care policies to patients and responsible parties on request. No amount of patient charges shall be reported or classified as charity care unless the health care facility has procedures in effect to supply such copies;*

(b) The amount to be reported or classified as charity care shall not include professional fees unless such fees are for services rendered by professionals directly employed by the health care facility;

(c) Patient charges for medical services rendered shall not be reported as charity care unless the health care facility has obtained documentation of the individual or family income of the patient who receives such services or the responsible party for such charges.

1. *The documentation obtained and maintained must demonstrate that the amount of patient charges to be reported and classified as charity care meets the income-testing standards of the health care facility's charity care policy;*
2. *The health care facility shall maintain documentation of a patient's or responsible party's application for financial assistance through the health care facility's charity care program and policies including, but not limited to:*
    i. *Individual Financial Documents such as tax forms, pay stubs, documentation of income, etc.;*
    ii. *the health care facility's documentation of financial questionnaires or interviews, if any;*
    iii. *Documentation of additional or other medical bills for which the patient or responsible party is responsible;*
    iv. *Documentation of the methods used to determine that the patient or responsible party may be classified as charity care; and*
    v. *Documentation of any and all collection efforts made; and*
3. *The health care facility shall only report and classify as charity care the amount of patient charges for services rendered that meet the income-testing standards of the health care facility;*

(d) Patient charges for medical services rendered shall not be reported as charity care if such charges otherwise meet the definition of bad debt;

(e) Patient charges for medical services rendered shall not be reported as charity care if the health care facility has pursued adverse collection practices against the patient or responsible party for payment of the services to be so designated.

1. *Adverse collection practices are those practices employed to collect payment for services rendered the outcome of which may cause an adverse affect to the patient's or responsible party's financial status. Adverse collection practices include, but shall not be limited to:*
    i. *Placing a lien against the personal or real property of the patient or responsible party;*
    ii. *Reporting failure to pay for the services to credit reporting agencies;*
    iii. *Garnishing the wages of the patient or responsible party;*
    iv. *Seeking any judgment or recovery from a Court of Law or Equity;*
    v. *Pursuing any collection action or policy which does not comply with the Fair Debt Collection Practices Act; and*
    vi. *Selling the patient's account for such services to a third party collection or recovery agency which retains a percentage of any such collection or recovery;*

2. *Adverse collection practices do not include referring the patient's account for such services to a third party collection or billing agency which is paid a set fee by the facility or provider for rendering such billing or collection services, provided that the health care facility has notified the collection or billing agency of its charity care policies and has contracted with such agency to follow and apply such policies; and*
3. *The health care facility shall have written policies about when and under whose authority any debt for services rendered is advanced for collection.*

Kurt Stuenkel commented, in reference to 14b, that language be included to reflect other types of financial arrangements other than what is stated.

Mr. Rozier suggested the sentence be changed to "the amount to be reported or classified as charity care shall not include professional fees unless such fees are for services rendered by professionals directly employed or under contractual arrangement with the health care facility …and the health care facility directly bills for such professionals." Mr. Stuenkel agreed that this proposed language would be appropriate.

COMMITTEE DISCUSSION/EDITS OF PROPOSED DEFINTIONS

Dr. Williams invited committee members to edit the proposed definitions.

- BAD DEBT

Mr. Rozier proposed that the committee consider Mr. Crudele's suggested definition, to link the definition of bad debt throughout the document rather than to restate it. Committee members agreed with this recommendation.

- CHARITY CARE

Dr. Williams guided the group through the process of editing the "charity care" definition.

Mr. Crudele expressed some concerns about item 14(a) 1; specifically stating that "financial counseling" is a broad term. He also expressed concern regarding the last sentence in item 14(a) 2 …"No amount of patient charges shall be reported or classified as charity care unless the health care facility has posted such notices". He said that this measure might be unnecessarily punitive. He agreed to Mr. Rozier's suggestion that the sentence could be worded as follows: "The Department may exclude charges which are reported as indigent and charity care if the health care facility has not posted such notices".

In reference to item 14(c), Mr. Calhoun suggested that the word "obtained" be replaced or omitted. To this, Mr. Stuenkel suggested that the term "obtained documentation of" be replaced with "determined individual or family income". The group agreed, and Mr. Rozier agreed to make these changes.

Mr. Crudele objected to including "income-testing" standards in item 14(c) 3, however Mr. Rozier pointed out that the group is interested in knowing the income standards in this case, because there are portions of charity care that can be written off. The amount of charity care that is written off by providers is only the portion that meets the income testing standards. Given the committee's objection to the term "income-

testing", this word was deleted from 14(c)1.

Mr. Calhoun expressed some concern about third party payors as it relates to 14(e) 1(iv). Mr. Stuenkel suggested including the term "responsible party". Mr. Rozier suggested the sentence read as follows: "Seeking any judgment or recovery from the patient or responsible party from a Court of Law or Equity."

In reference to Item 14(e) 1(vi), after some discussion concerning language such as "selling" of a patient's account, it was agreed that the item should read as follows: "Selling the patient's account for such services to a third party collection or recovery agency."

For Item 14(e) 2, the committee agreed to:

- delete the word "set" but retain the word "fee"
- replace the words "has contracted with" with the word "required".

Following the proposed changes, the committee approved the proposed definition for "Charity Care".

- INDIGENT CARE

Mr. Rozier pointed out that since this definition is the same, with the exception of a couple of items, then all changes agreed upon with the Charity Care definitions should be carried over to the Indigent Care definition as appropriate and necessary. Following the agreed upon changes, the committee approved the definition for "Indigent Care".

DEFINITION OF INDIGENT AND CHARITY CARE COMMITMENT

Department's Proposed Language:

(29.1) "Indigent and Charity Care Commitment" means a commitment to provide indigent and charity care as a condition and obligation to receive a certificate of need. Any such commitment made after the effective date of this definition shall be conditioned on the provision of services for inpatient and/or outpatient medical care, as applicable, the charges for which are appropriately designated as indigent and/or charity care and for which are provided at a ratio of three percent of the total charges for the facility or service, which ever is applicable.

Committee members voted to accept the Department's proposed language.

CALCULATION OF INDIGENT & CHARITY CARE COMMITMENTS

Dr. Williams called upon Mr. Rozier to explain how the calculation of indigent and charity care would be made, as shown in Appendix B, Page 10.

Mr. Rozier explained that the original proposed indigent & charity care commitment calculation formula was as follows:

$$\frac{\text{Average Reimbursement for Indigent \& Charity Care Services}}{\text{Total Charges minus Medicaid \& Medicare Contractual Adjustments and Bad Debt}}$$

Mr. Rozier presented the new proposed calculation formula as follows:

$$\frac{\text{Total Charges for Indigent \& Charity Care}}{\text{Total Charges}}$$

He pointed out that the new proposal is more an "apples to apples" comparison, since the Medicaid/Medicare contractual adjustments, which are the items that vary from facility to facility, are no longer a factor in the denominator.

Mr. Calhoun commented that the new proposal is more helpful; however it increases the burden on providers in terms of the amount of charity care that would have to be provided since the denominator is now a larger number. He expressed concern over the impact of such a formula on providers' ability to meet their commitment.

Mr. Greene asked Mr. Calhoun whether he agreed that the new formula provides an "apples to apples" comparison. Mr. Calhoun agreed that it did.

Mr. Stuenkel agreed that the formula is a "gross to gross" measure, but argued that the applicability of it is a concern in terms of providers meeting their 3% commitment.

Mr. Greene pointed out that Mr. Rozier wrote the proposed rule in such a way that it is prospective because there are many CON decisions that were written when the current formula was actually written into the decision.

Mr. Rozier also noted that the Department's current formula has never been incorporated in a rule. He said that the Department would like to incorporate this formula into a rule in order to formalize the process and to ensure consistency. He noted that the formula has been changed in the past because it was not in a rule.

Mr. Crudele asserted that potential changes to the formula could have huge and unintended consequences, because its impact has not been studied. He said that a change in the calculation is beyond the scope of what the committee has been asked to do. He noted that if the committee is going to contemplate such a major change, that members need to be provided with data to understand the potential consequences. He questioned whether Department staff had examined any data to determine what the consequences of such a change would be.

In response to Mr. Crudele's comments on the committee's scope, Mr. Greene disagreed and noted that this is the issue that originally raised the flag for the Department and the issue from which the committee's discussion originated. He pointed out that hospitals have had difficulties trying to figure out how to come up with Medicare/Medicaid cost adjustments and calculations under what the Department thought was a simple formula and definitions. He noted that this created variations in calculations around the state. He said that the Department sampled a variety of small/large, urban/rural, profit/non-profit hospital data to test the formula and there was very little adverse impact. He stated that there were some facilities that had fallen under the 3% requirement. He noted that the Department did not run the formula on every hospital,

because standardizing the formula and making it an "apples to apples" comparison was the right thing to do, not because of how it affects particular hospitals.

Mr. Stuenkel stated that this proposed formula is a step in the right direction, considering the number of uninsured Georgians and the fact that the burden of indigent care needs to be more equally distributed. He pointed out that providers other than hospitals establish freestanding services, and that other providers should be considered, particularly given the actions of the Board of the Department of Community Health in the recent past, with regard to providers that operate via Letters of NonReviewability (LNRs). He said that these requirements should apply to all providers.

Mr. Rozier asserted that the Department of Community Health only has authority to regulate and monitor providers that receive CONs. He explained that for this reason it is important to create a standardized system of calculation.

Mr. Stuenkel stated that since the proposed definitions and formula represent a sweeping change and the implications are unknown, that the Department should study the implications of this proposed formula on each segment of the industry, and be prepared to discuss this issue further at the next meeting. The committee agreed with Mr. Stuenkel's recommendation.

Dr. Williams clarified that defining indigent care, charity care, and bad debt were simply steps towards defining a new formula. Mr. Crudele requested that the Department provide more data on the potential implications of the proposed formula on statewide providers.

SCHEDULE OF UPCOMING MEETINGS

Following committee discussion, it was agreed that the next meeting would be held on Friday, January 14, 2004 from 1:30 pm - 3:30 pm at Southside Medical Center, 1046 Ridge Avenue, SW, Atlanta, GA 30315.

ADJOURNMENT

Dr. Williams thanked Department staff for their work and committee members for reaching a consensus on the definitions. He urged the committee to continue to send any written comments to Stephanie Taylor at sttaylor@dch.state.ga.us or directly to him at david.williams@southsidemedical.net

There being no further business, the meeting adjourned at 2:54 pm.
Minutes taken on behalf of Chair by Geeta Singh and Stephanie Taylor.

Respectfully Submitted,

David M. Williams, MD, Chair

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INDIGENT & CHARITY CARE AD HOC COMMITTEE
Friday, December 10, 2004

APPENDIX A

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Savannah
Plastic Surgery

Lawrence E. Ruf, M.D., F.A.C.S.*†
Scott W. Vann, M.D., F.A.C.S.*
Barbara L. Davies, M.D., F.A.C.S.*†
F. Chris Pettigrew, M.D., F.A.C.S.*
James L. (Beau) Fowler, M.D.
E.D. DeLoach, M.D., F.A.C.S.*†

*Diplomates
American Board of Plastic Surgery

12/10/04

REMARKS TO THE INDIGENT CARE COMMITTEE

This committee has been tasked with defining indigent care. It is my understanding that these definitions will apply to freestanding ambulatory surgery centers as well. I believe it is important that the voice of the private practice be heard as this is defined.

The six surgeons at Savannah Plastic Surgery wrote off over 2 million dollars in the practice last year. This includes their work at the hospital. They wrote off an additional 81 thousand dollars in the surgery center.

Our surgeons cover city-wide call for all three emergency rooms. Much of our work is done at the hospital on seriously injured patients. These patients are treated regardless of their ability to pay. Several surgeons are fellowship trained in hand surgery and treat industrial hand injuries. One of our surgeons works at the cleft palate clinic. At least two surgeons go to Guatemala each year and do surgery as mission work through "Faith in Practice".

Why is this work not done in our surgery center? We are a single specialty center. This restricts, for safety sake, and by insurance plans, what can be done in our surgery center. If a patient is involved in a major auto accident, they are brought to the hospital. They must be stabilized and then the surgeons go to work. We may be called in for an orbital fracture while a general surgeon is called in due to a ruptured spleen. It would be outside the standard of care to transfer the patient to our surgery center in order to get our indigent care quota. The general surgeon cannot operate in our surgery center, because we are single specialty.

While we are not providing these services in our surgery center, the owners of the surgery center are providing care, regardless of the ability to pay, in the appropriate facility. All of our surgeons are required to be owners of the surgery center by law. I believe our write-offs for the practice as a whole, sould count toward any indigent or charity care quota applied to the group.

†Members of the American Society for Aesthetic Plastic Surgery

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